PRESCRIPTION REFILL FORM

___ Dr. Meeks ___Dr. Viswanath___ Dr. Chaiwatcharayut___ NP. Lo

NAME: ____ DATE: ______________

DOB: ____________________ CONTACT NUMBER: ________________________________

PHARMACY: ____

Medication #1: ____

Strength: ____

Directions: ____

Amount: ____

Medication #2: ____

Strength: ____

Directions: ____

Amount: ____

Medication #3: ____

Strength: ____

Directions: ____

Amount: ____

Do you want generic? YES ____ NO ____

Do you need this written for a 90-day supply (mail order)? YES ____ NO ____

How many refills do you need? ____

Are you taking this to Womack? YES ____ NO ____

Does your insurance require the use of a formulary? YES ____ NO ____

What pharmacy do you use? ____

Do you have any drug allergies? If yes, List: ____

Additional Comments: ____

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